

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HMO APPEAL AND
GRIEVANCE PROCESSES**

Overview



JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
OEI-07-94-00280

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To obtain a copy of this report, call the Kansas City Regional Office at (816)426-3697.

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TABLE OF CONTENTS

	PAGE
PURPOSE	1
BACKGROUND	1
FINDINGS	1
• Beneficiary Awareness	
• Communication of Denials	
• Compliance with HCFA Directives	
• Publications and Procedures	
• Statistics	
RECOMMENDATIONS	2
• Monitoring	
• Standard Language	
• Distinguishing Appeals and Grievances	
• Data	
• HMO/CMP Manual	
• Training	
RELATED REPORTS	5
Agency Comments	6
Appendix A: HCFA Response	A-1

Medicare HMO Appeal And Grievance Processes

PURPOSE

To examine the operations of the Medicare risk-based Health Maintenance Organizations' (HMOs) appeal and grievance processes.

BACKGROUND

The goals of managed care are to provide preventive and coordinated medical care, offer comprehensive benefits, and contain costs by using the most cost-efficient methods of treatment and preventing unnecessary care. Because the payment mechanism of HMOs may provide incentives to limit services, the Social Security Act requires establishment of two separate and distinct processes to handle Medicare beneficiary complaints.

The appeals process, which covers disputes involving denials of services or payment, begins within the plan and extends to outside administrative and judicial reviews. Regulations require a five-step appeals process and time limits for each step.

The grievance process involves disagreements relating to services furnished for which the beneficiary has no further liability for payment. It also includes such issues as quality of care, physician behavior, waiting times for services, and involuntary disenrollment. Grievance regulations do not contain time frames or specific levels of review but call for "timely" transmission, investigation, decision and notification of results.

We examined these processes through: a survey of 426 beneficiaries; a survey of 132 risk-based HMOs; analysis of written procedures and marketing/enrollment material from these HMOs; and on-site reviews of 10 HMOs where we interviewed staff and examined 144 appeal and 148 grievance case files.

FINDINGS

BENEFICIARY AWARENESS. A majority of beneficiaries are aware they have the right to formally complain about services and payments. However, they have less understanding of the particular circumstances under which these rights can be exercised.

Eighty-six percent of respondents stated that they know they have the right to complain about their plan's medical care or services. However, one-third of beneficiaries did not know or were not sure of their right to complain about specific problems for which filing an appeal or grievance is possible.

COMMUNICATION OF DENIALS. The communication between the HMO and the beneficiary that a service or payment has been denied does not work well.

When an HMO denies a service or payment, the HMO is required to issue a written explanation for the denial, including the right to appeal. Thirty-four of 41 surveyed beneficiaries who believed they had been refused referral to a specialist indicated they did not receive a denial letter. Also, our review of cases revealed that 39 out of 144 files lacked documentation that service or payment denial notices were sent and an additional 6 cases did not include the required instructions on the beneficiaries' right to appeal the decision.

COMPLIANCE WITH HEALTH CARE FINANCING ADMINISTRATION (HCFA) DIRECTIVES. HMOs do not fully comply with HCFA directives for processing appeals and grievances.

Through our case reviews we noted problems involving failure to notify beneficiaries of their appeal and grievance rights and lack of or delays in processing, referring, and resolving complaints. Furthermore, HMOs do not always correctly categorize appeals and grievances. Fifty percent of those we surveyed incorrectly categorized appeals as grievances while all 10 HMOs we visited improperly processed from 1 to 12 appeal cases as grievances. This distinction is important to beneficiaries because appeal cases are subject to independent Federal review for appropriateness of the HMO decision while disputes involving grievance issues are only subject to internal HMO reviews.

PUBLICATIONS AND PROCEDURES. HMOs' marketing/enrollment materials and operating procedures that we reviewed contain incorrect or incomplete information on appeal and grievance rights.

Sixty-six percent of HMOs distribute materials to beneficiaries and 69 percent of HMOs use operating procedures that contain either incorrect or incomplete information regarding beneficiary appeal and grievance rights.

STATISTICS. HMOs do not maintain statistical information needed for the ongoing evaluation of appeal and grievance practices.

Eighteen percent of HMOs in our sample could not produce statistical information relating to numbers of appeal and grievance cases. This poses significant problems given that such statistical information is needed by HCFA, beneficiaries, and others as a basis for evaluating HMO performance.

RECOMMENDATIONS

HCFA's Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has created the Managed Care Appeals and Grievance Initiative work group organized to make program improvements in these functions. In 1995, they revised the annual review guidelines and standardized

language in the "lock in" and "Evidence of Coverage" notices. The 1996 Medicare Handbook also included expanded appeal and grievance information and was sent to all Medicare beneficiaries. Additionally, HCFA is developing national guidelines for marketing materials, improving publications, educating outside entities, and highlighting beneficiary rights. While these efforts should favorably impact these processes, we believe there is still room for improvement.

We recommend that HCFA take a number of actions to address problems highlighted in our studies.

- ***MONITORING. Actively monitor HMOs to ensure beneficiaries are issued written determinations, including appeal rights, and emphasize the need for beneficiaries to communicate clearly any disagreement they have with HMO decisions to deny services or payment for services.*** This can be accomplished by:

- continuing HCFA's extensive efforts to make beneficiaries aware of appeal and grievance provisions and of the need to communicate clearly any disagreement they may have with a physician's decision to deny a requested service and
- emphasizing to HMOs the requirements to make beneficiaries aware of appeal and grievance rights and to provide written initial determination notices when the patient communicates disagreement with a decision to deny a requested service or payment.

Federal regulations are intended to protect the rights of beneficiaries to appeal the denial of services by HMOs, while maintaining the ability of the physician to treat the patient in line with his or her medical judgment. It is not always possible at the time of service for the physician to know whether a beneficiary believes that a service has been denied unless the beneficiary specifically communicates this to the physician. Therefore, future HMO marketing, enrollment, and awareness sessions with Medicare beneficiaries and physicians should emphasize the importance of clear and open communication.

- ***STANDARD LANGUAGE. Work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.***

- In marketing materials, provide up front information to beneficiaries on their rights under the appeal and grievance processes and
- In enrollment materials, more thoroughly educate beneficiaries about their specific rights under the appeal and grievance processes, including

--a detailed overview of the types of services, lack of services, or situations which may be appealed or grieved.

- when and under what circumstances further levels of appeal are permitted.
- clarification that only appeals and not grievances, are subject to independent Federal review.
- the difference between the definitions of emergency and urgent care at the time medical services are being sought.

- ***DISTINGUISHING APPEALS AND GRIEVANCES. Ensure that HMOs correctly distinguish and process appeals and grievances.***

HCFA can accomplish this during their annual visits to HMOs. However, we suggest that HCFA conduct case reviews as well as examine the operating procedures to determine that appeals and grievances are processed correctly. We also suggest that HCFA focus closely on whether HMOs:

- are in compliance with all directives in processing of appeal and grievance cases;
- include appeal rights in all initial determinations sent to beneficiaries; and
- release initial determinations and reconsideration decisions in appeal cases according to established time frames.

- ***DATA. Require HMOs to report Medicare contract specific data on appeal and grievance cases.*** At a minimum, include:

- number of appeal and grievance cases (including formal and informal grievances);
- number of cases resolved internally and externally, and outcomes of cases;
- issues involved in cases; and
- time it takes to resolve the cases (upper and lower limits, median/mean).

- ***HMO/CMP¹ MANUAL. Modify the HMO/CMP Manual to clarify and specify key requirements.*** This can be achieved by:
 - clarifying the explanation and language required on the appeal and grievance issues to improve HMOs' understanding of the differences and
 - establishing minimum requirements for documentation of appeal and grievance files so that an independent reviewer, based upon examining the files, will be able to follow and understand the adjudication by the HMO.
- ***TRAINING. Broaden efforts to formally train HMOs on the appeal and grievance processes.***

We noted a significant amount of turnover in HMO staff responsible for processing appeals and grievance cases during this inspection. In light of this turnover, there is a need to continue training on a routine basis.

RELATED REPORTS

Details concerning the findings and recommendations in these reports are contained in three separate technical reports. These reports are:

Medicare HMO Appeal and Grievance Processes:
Beneficiaries' Understanding, (OEI-07-94-00281)

Medicare HMO Appeal and Grievance Processes:
Survey of HMOs, (OEI-07-94-00282)

Medicare HMO Appeal and Grievance Processes:
Review of Cases, (OEI-07-94-00283)

Copies of these reports may be obtained from the Kansas City Regional Office, Office of Inspector General at (816) 426-3697.

¹ Competitive Medical Plan

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. The complete text of their response is included as an appendix to this report. A summary of their comments and our response follows.

The HCFA agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

Although HCFA acknowledges the case review report identifies mistakes made by health plans, they expressed concerns about the sample sizes and number of cases reviewed. We agree that this sample could not be used to make national projections of the incidence of mistakes. However, the number of cases reviewed and outcomes of the reviews are more than adequate to indicate the existence of significant problems in HMO processing of appeals and grievances.

Finally, HCFA raised questions about the knowledge and expertise of the individuals who prepared the HMOs' responses to our survey documents. We requested and must assume that knowledgeable HMO staff completed our survey. We also note that beneficiaries making inquiries regarding appeals and grievances are likely to be interacting with these same individuals or their staff.

APPENDIX A

Health Care Financing Administration Response to Report



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DEC 12 1996

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Medicare HMO Appeal and Grievance Processes--Overview," (OEI-07-94-00280); "Medicare HMO Appeal and Grievance Processes--Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare HMO Appeal and Grievance Processes--Survey of HMOs," (OEI-07-94-00282); "Medicare HMO Appeal and Grievance Processes--Review of Cases," (OEI-07-94-00283)

We reviewed the above-referenced reports that examine the operations of the Medicare risk-based HMOs appeal and grievance processes. We agree with the conclusion of your report that improvements are needed and are working to implement a number of your recommendations. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this report.

Attachment

**Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG)**

**Draft Reports: "Medicare Health Maintenance Organizations' (HMO) Appeal and
Grievance Processes: "Overview," (OEI-07-94-00280); Medicare HMO Appeal and
Grievance Processes: "Beneficiaries' Understanding," (OEI-07-94-00281); "Medicare
HMO Appeal and Grievance Processes: "Survey of HMOs," (OEI-07-94-00282);
"Medicare HMO Appeal and Grievance Processes: "Review of Cases,"
(OEI-07-94-00283)**

OIG Recommendations

OIG recommends that HCFA take the following actions to address problems highlighted in the above studies:

- o Actively monitor HMOs to ensure beneficiaries are issued written determinations.
- o Work with HMOs to establish standardized appeal and grievance language requirements in marketing/enrollment materials and operating procedures.
- o Ensure that HMOs correctly distinguish and process appeals and grievances.
- o Require HMOs to report Medicare contract-specific data on appeal and grievance cases.
- o Modify the HMO/CMP Manual to clarify and specify key requirements.
- o Broaden efforts to formally train HMOs on the appeal and grievance processes.

HCFA Response

We agree that improvements are needed. We have a comprehensive effort underway called the Medicare Appeals and Grievance Initiative (MAGI) which includes a number of objectives that are directly related to the recommendations in your reports. Our objectives include identifying and meeting the information needs of beneficiaries regarding their appeal rights; promoting health plan accountability by developing and improving information on appeals and making meaningful information more available; and refining mechanisms for monitoring and assisting in the continuous improvement of health plan performance.

OIG and HCFA jointly issued a Medicare beneficiary advisory bulletin entitled, "What Medicare Beneficiaries Need to Know About HMO Arrangements: Know Your Rights." This easy-to-read document contains information on appeal rights, filing complaints, and rights to emergency and urgently needed services. Copies of this bulletin are being distributed nationally. Additionally, significant changes were made to improve the managed care portions of the Medicare Handbook, which was sent to all beneficiaries this year. New data reporting requirements on plan-level reconsiderations are under development and may be instituted as early as mid-1997. We also plan to restructure and shorten the time lines for handling health care decisions and reconsiderations by health plans.

Beneficiaries' Understanding

We are pleased to see the high level of knowledge among Medicare enrollees regarding their right to appeal and file complaints. This is an improvement over an earlier finding, and one we believe results from both Federal program and plan efforts at educating beneficiaries and providing notices. With regard to the finding that beneficiaries had a lesser level of awareness as to when to exercise their appeal rights, forthcoming regulations clarifying the right to appeal when services are reduced or terminated, and when to provide notices of noncoverage at these points in care management, should significantly help address this problem. We will consider the recommendations in this area.

Survey HMOs

Incorrect categorization of appeals as grievances is an area for improvement identified in our MAGI initiative. However, we question the percentage and methodology set forth in this report. Because certain staff within the organizational structure of an HMO, or staff at delegated medical groups within the HMO's network, are generally responsible for assigning complaints to the appeals or grievance track, it would be important to know who responded to the two questions asked on this subject and what role they play in this particular process. We will be moving to identify the source problems, such as staff turnover and confusion over differences in Federal and state terminology.

The type of statistical information sought by OIG staff has not been a requirement for Medicare-contracting health plans. Therefore, it is not surprising that many plans aggregate the appeals information across commercial, Medicare, and Medicaid members. New plan-level appeals reporting requirements should resolve the need for Medicare-only information, and respond to your recommendation.

Review of Cases

We have concerns about the small sample sizes and number of cases used to present findings in this report. However, the report identifies the types of mistakes health plans make in operating an appeals system, and the needs that plans have for clear, distinct information and training about the Medicare managed care requirements (and how these differ from state requirements for their commercial and Medicaid enrollees). We will consider the recommendations presented.